Department of Public Works and Engineering

Subject: LEAVE OF ABSENCE	Departmental Policy 3-34
	Effective Date: **Upon Approval**

I. Purpose

To ensure that requests for personal leaves are granted in such a manner that the Department's needs, as well as the employee's, are considered prior to their leave being granted.

II. Scope

This policy applies to all Department of Public Works and Engineering employees and supersedes any other former Departmental policy, procedure or directive.

III. Policy

All "Leaves of Absence Without Pay" for foreseeable events must be requested at least 30 days prior to the date the leave is to begin. (For instance, it is not "foreseeable" when an employee becomes ill suddenly or has a death in the family.)

Assistant Director or Designee may grant, upon good reason, leaves of absences (Docks) for as many as fourteen (14) consecutive calendar days for permanent employees.

Before a "Leave of Absence Without Pay" for a medical reason(s) is granted, the employee must use all available sick leave. If the Leave is for a non-medical reason(s), the employee must use all vacation leave.

Every "Leave of Absence Without Pay" **must** be carefully reviewed by the employee's supervisor with consideration given to the employee, but also keeping in mind the immediate needs of the Division as well as this Department. Approval of all requests for "Leaves of Absence Without Pay" will be made strictly on a case-by-case basis, meaning there will not be "automatic" granting of any request. "A Leave of Absence Without Pay" will only be considered if the employee is not eligible for FML or has exhausted all FML benefits. The employee's reasons for requesting a Leave, especially when the need for the Leave is unforeseen, shall provide sufficient information for the Leave to be appropriately determined and designated. Failure to provide such notice and/or medical justification will be grounds for denying the Leave.

If a "Leave of Absence Without Pay" is warranted, having been determined from the medical and/or personal statement provided by the employee and the immediate needs of the Division/Department, the exact number of days allowed will be made strictly on a case-by-case basis. Departmental "Leaves of Absence Without Pay" shall be granted in up to ninety (90) calendar day increments (which include the fourteen (14) calendar day absences granted by the Assistant Director or Designee) and shall not exceed one-hundred eighty (180) calendar days in a twelve month period. The employee can return at any time during the Leave of Absence.

A "Request for Leave of Absence without Pay" form (Attachment A) must be completed and submitted for approval on all Leave requests. Attached must be the medical and/or personal statement, a printout (Attachment B) of the employee's leave balances showing sick or vacation has been exhausted, a City of Houston - Family/Medical Leave Form (Attachment C) indicating the employee's choice whether or not to continue Basic Life, Voluntary Life, Medical and/or Dental coverage along with a Change Form (Attachment D) to stop deductions, if applicable.

While on an approved Leave of Absence for medical reasons, the employee will provide updated medical documentation from the treating physician every fourteen (14) calendar days and/or upon request by the employee's Division. If the "Leave of Absence" is for a non-medical reason, the employee will provide a signed statement every fourteen (14) calendar days explaining the need to continue on leave without pay status. An employee who fails to provide the required documentation may be subject to discipline up to and including indefinite suspension.

If the Division reasonably doubts the validity of the medical information provided by the employee, the Division may request the City physician or designee to communicate with the employee's health care provider for the purpose of clarifying and/or authenticating such medical certificates. The Division may require an examination by a second health care provider designated by the Division and at the Division's expense based on the findings of the City physician or designee.

If the opinion of the second health care provider conflicts with the employee provided medical certification, the Division, at its expense, may require a third, mutually agreed upon between the Division and the employee, health care provider to conduct an examination and provide a final and binding opinion. Employees shall cooperate fully, completely, and timely with all requests for additional medical opinions.

An employee on "Leave of Absence Without Pay" shall report periodically to the Assistant Director or Designee regarding the intent to return to work. Such reports shall generally be made by telephone twice a week, or more frequently as needed, considering the relevant facts and circumstances related to the employee's leave status.

NOTE: Employees shall not engage in outside employment while on Leave of Absence.

During a "Leave of Absence Without Pay" an employee shall receive coverage under the City's group health plan provider PROVIDED premiums for his/her share is paid by the employee directly to the Benefits Division of the Human Resources Department, or to a Carrier, as appropriate to maintain coverage.

An employee on a "Leave of Absence Without Pay" does **NOT** accrue any benefits during the period of the Leave. This will include service credit for pension, both MSP and CSL sick plans, and vacation.

Any employee who is out over ninety (90) calendar days will have his/her Certification Date (C.D.) adjusted upon return from the Leave.

When an extended "Leave of Absence" is taken, it is possible that the employee may not be able to return to the exact same work site and duty assignment. If that employee's position becomes critical during his/her absence, the position may be filled and the employee may be reassigned.

Upon returning to work an employee who used a "Leave of Absence Without Pay" because of his/her own medical condition, must **immediately** provide a physician's statement indicating that he or she is released to duty and able to return to work.

An employee who fails to provide the required medical information will not be permitted to resume work until the documentation is provided and may be subject to discipline, up to and including indefinite suspension.

In the event the reason for which the employee is taking a "Leave of Absence Without Pay" ceases, the employee will immediately report the information to the supervisor and make arrangements to return to work. If an employee who fails to return to work upon expiration of the "Leave of Absence Without Pay" within 3-calendar days, and/or fails to report changes in the reason for the continued leave, the employee may be subject to discipline up to and including indefinite suspension.

Upon returning to work an employee who chose NOT to retain Life, Medical, and/or Dental coverage during the Leave of Absence Without Pay must complete Medical/Dental Election Form (Attachment E), Basic Life Insurance Enrollment Form (Attachment F), and Voluntary Life Insurance Enrollment Form, if applicable (Attachment G). The employee must satisfy a ninety (90) day eligibility period for life, medical and the (DHMO) dental health maintenance organization plan and a one-hundred eighty (180) day eligibility period for the indemnity dental plan.

An employee shall not forge, tamper with, alter, or falsify any official forms, physician's statement, or City document, nor make a false statement related to the request for "Leave of Absence Without Pay," the eligibility or continual eligibility for Leave Without Pay and/or other related benefits or conditions. To do so will result in disciplinary action, up to and including indefinite suspension.

IV. Compliance

This applies to non-work related absences:

Employees are subject to and must follow all applicable City/Departmental policies and directives while on a "Leave of Absence Without Pay," including, but not limited to, the duty to comply with the City's policy regarding Outside Employment (Policy 3-14) and, where applicable, the requirement to submit to a test for controlled substances as required by the Mayor's Drug Detection Policy 1-12.

This applies to work-related absences:

Employees are subject to and must follow all applicable laws and regulations relating to worker's compensation including the City of Houston Work Ability Guidelines, Executive Order 1-33 (April 1, 1995) and any subsequent amendments, while on a "Leave of Absence Without Pay."

Adherence to the above is mandatory. Any employee who violates this policy may be subject to disciplinary action, up to and including indefinite suspension.

From PUBLIC WORKS & ENGINEERING DEPARTMENT

Date:

REQUEST FOR LEAVE OF ABSENCE
WITHOUT PAY

DATE _____

EMP. NAME _____ S.S. # _____

SUPERVISOR _____ PHONE # _____

PAYROLL DEPT. _____ PAY LOC/WORK LOC _____

A Leave of Absence w/o pay is requested
for the following reason:

(1) _____ Personal Business
Reason/Comments:

(2) _____ Medical/On The Job Injury - attach medical documentation

(3) _____ Military Leave - attach orders

(4) _____ Administrative LOA (To be requested only by supervisor when employee has been docked in excess of 14 calendar days. Supervisor should attach report explaining request.

Number of calendar days requested: _____ (No more than 90 calendar days at a time may be requested); beginning _____ and ending close of business _____ Extension of Leave ____ Yes ____ No

PAID LEAVE BALANCES:

Sick Leave (full pay) _____ hrs.
Sick Leave (half pay) _____ hrs.
Vacation Leave _____ hrs.

NOTICE TO EMPLOYEE

The employee is responsible for personally paying all payroll deductions they wish to keep in force to the proper vendor. The employee is also responsible for submitting stop deductions for all deductions that should not start-up on the return to work. This is to prevent paying for policies that have lapsed during employee's absence. The Family Medical Leave Form must be completed. Changes may be made to this request if necessary by management. Such changes will be initialed with a copy of the final form given to the employee. The original will go to Pay Systems Management Section.

* **FAILURE TO RETURN WITHIN THREE (3) DAYS FROM A LEAVE SHALL BE TAKEN AS EVIDENCE OF A RESIGNATION WITHOUT NOTICE.**

_____ Supervisor/Manager

_____ Employee Signature

Approved:

Concur:

_____ Assistant Director

_____ Director

PW 265 REV 6/95

Policy 3-34
Attachment A

MODE: R SCREEN: QLBL USERID: E095 06/05/97 14:33

EMPLOYEE LEAVE BALANCE INQUIRY

EMPLOYEE ID: APPT ID: NAME:
CATEGORY: DATE: 06 97 (MM/YY)

LEAVE CATEGORY	BALANCE	AMT BASIS	BAL TYPE	LEAVE YR END MO
ILEVB INJURY LEAVE BALANCE	0.00	HOURS	ID	
IWOP INJURY LEAVE WITHOUT PAY	0.00	HOURS	ID	
LWOP LEAVE WITHOUT PAY	0.00	HOURS	YD	
MSP85 MSP SICK LEAVE	0.00	HOURS	ID	
MSP86 MSP SICK LEAVE	0.00	HOURS	ID	
MSP87 MSP SICK LEAVE	0.00	HOURS	ID	
MSP88 MSP SICK LEAVE	0.00	HOURS	ID	
MSP89 MSP SICK LEAVE	0.00	HOURS	ID	
MSP90 MSP SICK LEAVE	0.00	HOURS	ID	
MSP91 MSP SICK LEAVE	0.00	HOURS	ID	
MSP92 MSP SICK LEAVE	0.00	HOURS	ID	
MSP93 MSP SICK LEAVE	0.00	HOURS	ID	
MSP94 MSP SICK LEAVE	0.00	HOURS	ID	

MODE: S SCREEN: QLBL USERID: E095 06/05/97 14:33

EMPLOYEE LEAVE BALANCE INQUIRY

EMPLOYEE ID: APPT ID: NAME:
CATEGORY: DATE: 06 97 (MM/YY)

LEAVE CATEGORY	BALANCE	AMT BASIS	BAL TYPE	LEAVE YR END MO
MSP95 MSP SICK LEAVE	0.00	HOURS	ID	
MSP96 MSP SICK LEAVE	0.00	HOURS	ID	
MSP97 MSP SICK LEAVE	0.00	HOURS	ID	
SICK CURRENT LEAVE YEAR SICK	0.00	HOURS	ID	
VACAB VACATION BALANCE	0.00	HOURS	ID	

H--YI103 END OF INQUIRY

Policy 3-34
Attachment B
(generated by Divisional timekeeper)

CITY OF HOUSTON BENEFITS CONTINUATION REQUEST FORM
(Non-Family/Medical Leave)

This form will serve ***"NOTICE"*** *that while I am on an unpaid absence other than FMLA (e.g., Leave of Absence Without Pay, Injury Leave, or on Dock Status), I will be responsible for payment of my insurance premiums. I understand that failure to make premium payments will result in termination of coverage, and upon returning to work, I must satisfy the applicable waiting period for Medical, Dental, Life, and AFLAC Insurance before I am eligible for benefits. Upon returning to work, I will only be entitled to the benefits I was receiving at the time of my leave.* ***I ALSO UNDERSTAND THAT I MUST CONTACT THE BENEFITS OFFICE UPON RETURNING TO WORK TO ENSURE BENEFITS CONTINUE WITH NO BREAK IN COVERAGE. (WORKER'S COMPENSATION DOES NOT PAY FOR BENEFITS WHILE AN EMPLOYEE IS OUT ON INJURY.)*** *For information, please contact ABEL MALDONADO at (713) 658-3731.*

IF PREMIUMS "WILL" BE CONTINUED, PLEASE COMPLETE AND SIGN PART I OF THIS FORM.
IF PREMIUMS "WILL NOT" BE CONTINUED, PLEASE COMPLETE AND SIGN PART II OF THIS FORM. **(PRINT OR TYPE ONLY)**

LAST NAME _____ FIRST _____ MI. _____ SOCIAL SECURITY NO. ___-___-____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____ HOME PHONE NO. (___)___-____

DEPARTMENT: _____ DATE OF LAST CHECK RECEIVED: ____/____/____

BRIEF EXPLANATION FOR LEAVE: _____

EMPLOYEE MUST COMPLETE THE "BENEFITS CONTINUATION REQUEST FORM" FOR ANY TYPE OF UNPAID LEAVE LISTED ABOVE OTHER THAN FMLA. THE BENEFITS OFFICE HAS THE RESPONSIBILITY TO STOP ANY SCHEDULED BENEFIT DEDUCTIONS DEEMED NECESSARY.

(PART I) *I* ***"AGREE"*** *to pay my premiums while I am on an unpaid absence other than FMLA (e,g., Leave Without Pay, Injury Leave or on Dock Status). The total monthly premium must be paid by* ***CASHIERS CHECK OR MONEY ORDER (ONLY)*** *made payable to the* ***CITY OF HOUSTON HEALTH BENEFITS FUND*** *(attach this form with your payment). Premium payments must be received in the* ***PERSONNEL DEPARTMENT, BENEFITS DIVISION, L.W.O.P SECTION, 500 JEFFERSON, 15th Fl., HOUSTON, TX. 77002,*** *by the end of each month. Payments for AFLAC coverage must be made payable to A.F.L.A.C. (SEE BACK OF FORM).*

I AM PAYING FOR THE AMOUNT(S) CHECKED BELOW, FOR THE PERIOD OF: _____

	NON-TOBACCO MONTHLY PREMIUM	TOBACCO MONTHLY PREMIUM	BASIC LIFE	DENTAL		TOTAL AMOUNT DUE
HMO				DMO	(__) $ 6.80	
Employee only	(__) $ 9.00	(__) $ 34.00	(__) $ 3.88	INDEMNITY	(__) $ 12.60	$_____
				DMO	(__) $ 13.60	
Employee + One Dependent	(__) $ 41.00	(__) $ 66.00	(__) $ 3.88	INDEMNITY	(__) $ 29.16	$_____
				DMO	(__) $ 19.50	
Employee + Two or More Dep.	(__) $ 54.00	(__) $ 79.00	(__) $ 3.88	INDEMNITY	(__) $ 39.80	$_____
POINT-OF-SERVICE				DMO	(__) $ 6.80	
Employee only	(__) $ 18.00	(__) $ 43.00	(__) $ 3.88	INDEMNITY	(__) $ 12.60	$_____
				DMO	(__) $ 13.60	
Employee + One Dependent	(__) $ 97.00	(__) $ 122.00	(__) $ 3.88	INDEMNITY	(__) $ 29.16	$_____
				DMO	(__) $ 19.50	
Employee + Two or More Dep.	(__) $ 122.00	(__) $ 147.00	(__) $ 3.88	INDEMNITY	(__) $ 39.80	$_____
OUT-OF-AREA				DMO	(__) $ 6.80	
Employee only	(__) $ 13.76	(__) $ 38.76	(__) $ 3.88	INDEMNITY	(__) $ 12.60	$_____
				DMO	(__) $ 13.60	
Employee + One Dependent	(__) $ 74.00	(__) $ 99.00	(__) $ 3.88	INDEMNITY	(__) $ 29.16	$_____
				DMO	(__) $ 19.50	
Employee + Two or More Dep.	(__) $ 93.00	(__) $ 118.00	(__) $ 3.88	INDEMNITY	(__) $ 39.80	$_____

Voluntary Life and General American Life Insurance: *Voluntary Life Insurance with ITT Hartford Insurance Company should also be included in the total premium that you pay. Enter your Voluntary Life Insurance premium here: $_____. Enter your General American Life Insurance here: $_____.*

TOTAL AMOUNT ENCLOSED: $_____

EMPLOYEE SIGNATURE: _____ **DATE:** ____/____/____

(PART II) *I* ***"DO NOT"*** *want to pay premiums while I am on an unpaid absence other than FMLA (e.g., Leave Without Pay, Injury Leave, or on Dock Status and I am aware that my Department Payroll Office will stop my scheduled premium deductions. I also understand that when I return to work, I must contact my Department Personnel Office or Payroll Representative to complete new forms to have my benefits reinstated.* ***(Coverage will start after applicable waiting period(s) are satisfied.)***

EMPLOYEE SIGNATURE: _____ **DATE:** ____/____/____

Form 1996-ATM 10/07/96

Policy 3-34
Attachment C (2-sided)

CITY OF HOUSTON BENEFITS CONTINUATION REQUEST FORM

(Non-Family/Medical Leave)

AFLAC

(BI-WEEKLY PREMIUMS)

PLEASE TYPE OR PRINT IN BLUE OR BLACK INK (ONLY)

Employee's Name (First, MI., Last) _____ Social Security No. ___/___/___

Address _____ Apt. No. _____ Home Phone (___)___-____

City _____ State _____ Zip Code _____ Birthdate ___/___/___

Department: _____ Sex: { } Male { } Female

PLEASE CHECK TYPE OF POLICY OR POLICIES MAINTAINED

CANCER POLICY:	{ } Individual Only	$ 11.00	{ } Family	$ 17.00
ACCIDENT/DISABILITY POLICY:	{ } Individual Only	$ 12.10	{ } Individual/Spouse	$ 14.75
	{ } Single Parent/Children	$ 16.90	{ } Family	$ 19.55

HOSPITAL INDEMNITY POLICY:

AGE AS OF LAST BIRTHDAY:	**0 thru 39**	**40 thru 49**	**50 thru 59**	**60 thru 64**
		$ 50.00 PER DAY BENEFIT		
INDIVIDUAL ONLY	{ } $ 3.55	{ } $ 4.85	{ } $ 6.85	{ } $ 8.75
SINGLE PARENT	{ } $ 5.90	{ } $ 7.15	{ } $ 9.15	{ } $ 10.65
FAMILY	{ } $ 8.75	{ } $ 11.05	{ } $ 14.25	{ } $ 17.50
		$ 75.00 PER DAY BENEFIT		
INDIVIDUAL ONLY	{ } $ 5.00	{ } $ 7.05	{ } $ 10.00	{ } $ 12.95
SINGLE PARENT	{ } $ 8.60	{ } $ 10.50	{ } $ 13.45	{ } $ 15.75
FAMILY	{ } $ 12.90	{ } $ 16.30	{ } $ 21.10	{ } $ 26.00
		$ 100.00 PER DAY BENEFIT		
INDIVIDUAL ONLY	{ } $ 6.50	{ } $ 9.20	{ } $ 13.20	{ } $ 17.10
SINGLE PARENT	{ } $ 11.30	{ } $ 13.80	{ } $ 17.75	{ } $ 20.85
FAMILY	{ } $ 17.00	{ } $ 21.55	{ } $ 27.95	{ } $ 34.55

PLEASE MAKE SEPARATE CASHIERS CHECK OR MONEY ORDER PAYABLE TO: A.F.L.A.C.

PREMIUMS ARE FOR MY AFLAC COVERAGE INDICATED ABOVE FOR THE PERIOD OF:

_____.

TOTAL AMOUNT DUE FOR AFLAC POLICY(IES): $ _____

EMPLOYEE SIGNATURE: _____ **DATE:** ___/___/___

CITY OF HOUSTON

BENEFIT CHANGE FORM

	Check all that apply				
Please complete and return this form to your Personnel Dept. Representatives for all changes that affect all eligible members. Failure to comply will affect benefits and receipt of ID cards.	**Plan** ☐ Medical ☐ Dental ☐ Both	**Change** ☐ Name ☐ Address ☐ Primary Physician ☐ DMO Primary Dentist ☐ Other _____	**Add Dependent** ☐ Marriage ☐ Newborn ☐ Other _____	**Cancel Dependent** ☐ Marriage ☐ Divorce ☐ Age Limit ☐ Other _____	**Cancel All Coverage** ☐ Terminate Employment ☐ Voluntary Withdawal ☐ Family Medical Leave ☐ Layoff _____ ☐ Other _____

Employee Last Name, Fist Name, Middle Initial	For Employer Use Effective Date of Coverage	Group Medical No. 50499P	Group Dental No. 35234	Department/Division
Social Security No. (Employee)	Previous Name (if this is a name change)	Home Phone Number (Area Code) ( )		
Street Address or P.O. Box #	Apt. No.	City	State	Zip Code

Add	Drop	Last Name, First Name	MI	Effective Date	Date of Birth	Relationship	Primary Care Physician Name	DMO Primary Care Dentist Name
						Employee		
						Husb | Wife		
						Son | Dau		
						Son | Dau		
						Son | Dau		

Membership granted to persons hereon shall be subject to all provisions and limitations of the HMO Group Service Agreement/Certificate of Coverage and Schedule of Benefits, the Point-of-Service document, and the DMO/Indemnity dental plan documents. I am aware that a change in dependents may affect the amount deducted from my wages and I hereby authorize such a change.

Benefit Adm. Signature | Employee Signature | Date Signed

White - **Benefits** Green - **SANUS** Yellow - **United Healthcare** Pink - **Department** Gold - **Employee**

Policy 3-34
Attachment D

1176 REV 4/95

CITY OF HOUSTON
MEDICAL/DENTAL ELECTION FORM

PRINT WITH BLUE OR BLACK INK ONLY OR TYPE

Dept: _____ SS#: _____ M/F (circle one)

Name: _____ DOB: _____

Address: _____
Street Address City State Zip

BENEFITS
FOR OFFICE USE ONLY
EE# _____
Hire Date: _____
Med. Eff. Date _____
Dent. Eff. Date _____

A. Group Benefits Choice

Medical (Select one only):
[ ] I Elect Medical Coverage
- [ ] Sanus HMO
- [ ] Point-of-Service Plan
- [ ] Out-of-Area Plan

[ ] I Waive Medical Coverage

Coverage Type:
[ ] Employee Only
[ ] Employee + 1 Dependent
[ ] Employee + 2 or More Dependents

Dental (Select one only):
[ ] I Elect United Healthcare Indemnity Plan
[ ] I Elect United Healthcare DMO Plan

Coverage Type:
- [ ] Employee Only
- [ ] Employee + 1 Dependent
- [ ] Employee + 2 or More Dependents

[ ] I Waive Dental Coverage

B. Complete the Following on Participants to Be Covered

Person	Med Y/N	Dent Y/N	Last Name, First, MI.	Social Security	Full-time Student Y/N	Date of Birth	Relation ship	Medical Plan Primary Care Physician	DMO Primary Care Dentist
Employee							SELF		
Spouse							HUSB/WIFE		
Dep.							SON / DAU		
Dep.							SON / DAU		
Dep.							SON / DAU		
Dep.							SON / DAU		

Eligible dependent means legal spouse and unmarried children (natural, adopted, foster, and/or grandchild(living with you in parent/child relationship) under age 19 or full-time students to age 25. Specific certification of dependent status may be required. Full-time student is defined as an eligible dependent enrolled in an accredited college, trade school or university for a minimum of 12 semester hours. It includes disabled dependents whose disability occurred prior to age 19.

C. Other Benefit Coverage

Is your spouse employed?
[ ] Yes [ ] No [ ] NA If Yes, name of Company: _____
Are you or your dependents covered for benefits by any other group **medical insurance** or medical care plan?
[ ] Yes [ ] No If Yes, name of Medical Plan Carrier: _____
Are you or your dependents covered for benefits by any other group **dental insurance** or dental care plan?
[ ] Yes [ ] No If Yes, name of Dental Plan Carrier: _____
I authorize any medical and/or dental provider or facility to disclose to the selected plan administrator any medical/dental information relating to individuals specified on this application.

D. Tobacco User Status

If you or a dependent use tobacco products, twelve dollars and fifty cents ($12.50) will be added to your bi-weekly medical deduction, regardless of your coverage category or the option you choose.
Do you or a covered dependent use tobacco products, or do you or your dependent(s) intend to use tobacco products in the future?
[ ] YES [ ] NO NOTE: If you answer "NO" and then use tobacco products in the future, you will lose medical coverage.

E. Section 125 Flexible Election

I understand that my medical, dental, and AFLAC premiums (if applicable) may be deducted on a pre-tax basis as outlined in Section 125. I further understand that my plan selection is irrevocable for the plan year.
[ ] I want my medical, dental, and AFLAC contributions (if applicable) deducted on a **pre-tax** basis.
[ ] I want my medical, dental, and AFLAC contributions (if applicable) deducted on a **post-tax** basis.

F. Employee Authorization of Payroll Deductions

I am an employee of the City of Houston, eligible to participate in the medical and dental program. I apply to participate and understand that the information I have provided above is part of my application. All statements made by me may be relied upon by the City; if any information that I have provided is found to be materially incorrect, my coverage may be denied. I realize that any coverage my dependents are eligible for at this time, which I decline, may not be available in the future, unless I provide proof of a change in family status or proof of insurability within the time period allowed by the plans. I agree that if I have listed ineligible dependents, my medical coverage may be canceled. I authorize the City of Houston to deduct from my wages or salary my portion of the contributions as they become due.

Date	Home Phone	Work Phone	Employee Signature

Policy 3-34 Attachment E

WHITE - **BENEFITS** • GREEN - **SANUS** • YELLOW - **UNITED HEALTHCARE** • PINK - **DEPARTMENT** •
PER 078 REV 4-95

CITY OF HOUSTON

BASIC LIFE INSURANCE ENROLLMENT FORM

For office use only
Employment Date_____
Effective date of coverage_____

Employee Name	Department:
Employee Mailing Address	Social Security Number:
(City) (State) (Zip)	Date of Birth:
Work Phone:	Home Phone:

NAMING THE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, date of birth, social security number, relationship, and, if a minor, the age of that minor. If you need assistance, contact your department personnel or your legal counsel.

PRIMARY BENEFICIARY

Name	Address	Date of Birth	Social Security #	Relationship	Age (if minor)
			- -		
			- -		
			- -		
			- -		

CONTINGENT BENEFICIARY

Name	Address	Date of Birth	Social Security #	Relationship	Age (if minor)
			- -		
			- -		

DEPENDENTS

Dependent means your spouse, biological child, stepchild, foster child, legally adopted child, and any child who lives with you and whom you claim as a dependent on your Federal Income Tax. An active City of Houston employee is ineligible to be a dependent under this policy.

Name	Address	Date of Birth	Social Security #	Relationship	Age (if minor)
			- -		
			- -		
			- -		
			- -		
			- -		

Employee Signature: **X**	**Date:** **X**

CITY OF HOUSTON

VOLUNTARY LIFE INSURANCE ENROLLMENT FORM

For office use only
Employment Date _____
Effective date of coverage _____

Employee Name	Department
Employee Mailing Address	Social Security Number
(City) (State) (Zip)	Date of Birth
Work Phone	Home Phone

❑ **I elect to apply for Voluntary Life Insurance Coverage.**
Request new coverage (A Personal Health Statement is required for any selection above 1x salary.)
1 x Salary _____ 2 x Salary _____ 3 x Salary _____ 4 x Salary _____
I hereby authorize the City of Houston to deduct from my earnings the necessary contributions to maintain voluntary life coverage.

❑ **I decline Voluntary Life Insurance coverage.**

NAMING THE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, date of birth, social security number, relationship, and, if a minor, the age of that minor. If you need assistance, contact your Department Personnel office or your legal counsel.

PRIMARY BENEFICIARY

Name	Address	Date of Birth	Social Security #	Relationship	Age (if minor)
			- -		
			- -		
			- -		
			- -		

CONTINGENT BENEFICIARY

Name	Address	Date of Birth	Social Security #	Relationship	Age (if minor)
			- -		
			- -		

DEPENDENTS

Dependent means your spouse, biological child, foster child, legally adopted child, and any child who lives with you and whom you claim as a dependent on your Federal Income Tax. An active City of Houston employee is ineligible to be a dependent under this policy.

List dependents to be covered.

Name	Address	Date of Birth	Social Security #	Relationship	Age (if minor)
			- -		
			- -		
			- -		

Employee Signature: X	**Date:** X

Policy 3-34
Attachment G